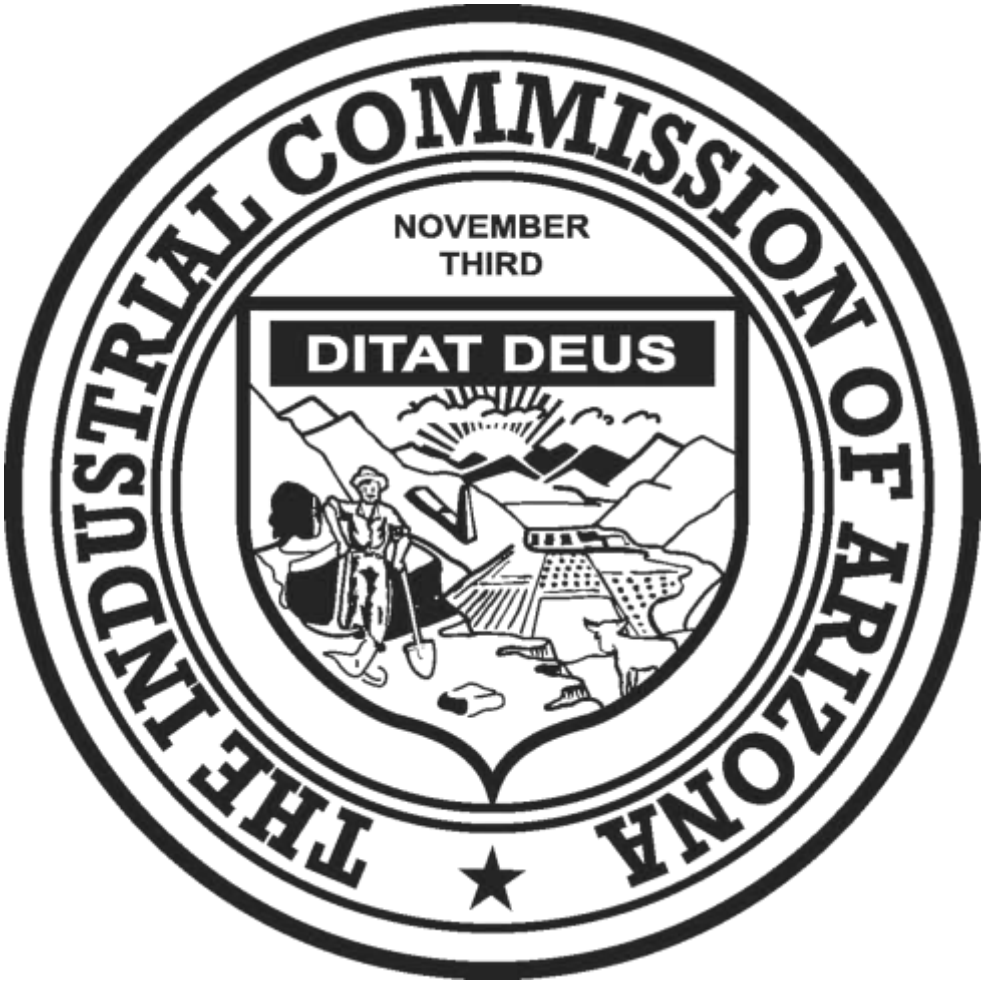
Claims Adjusting Overview

Presented By:

Ruby Tate, Claims Manager



Agenda

- Overview of the ICA Claims Division Role
- WC 101
- Solicitations

ICA Claims Division Role

2020 SEMINAR MANUAL, CLAIMS ADJUSTING

AGENCY INFORMATION | DIVISIONS | NEWS AND EVENTS | RESOURCES FOR | HOW DO I | ONLINE SERVICES | PAYMENT PORTAL

Home » Divisions » Claims Main Page

CONTACT INFO

Ruby Tate, Claims Manager
Melissa Smith, Ombudsman

Phoenix Office:
800 W. Washington St.
Phoenix, AZ 85007
Phone: (602) 542-4661

Tucson Office:
2675 East Broadway
Tucson, AZ 85716
Phone: (520) 628-5181

FAX : (602) 542-3373

General Questions:
Claims@azica.gov

Claims Forms

ADOSH

Claims Division

Serving the workers' compensation community by processing claims efficiently and effectively.

WORKERS' COMPENSATION INFORMATION

- Workers' Compensation for the Injured Worker
- Employers' Frequently Asked Questions about Workers' Compensation
- Gradual Injury
- Independent Medical Evaluations
- Permanent Impairment or Loss of Earning Capacity
- Loss of Job
- Uninsured Employers
- Vocational Rehabilitation ("Voc Rehab")
- Suspension of a Claim
- Exposure to Bodily Fluids

CLAIMS RESOURCES

- Average Monthly Wage Statutory Maximum
- Workers' Compensation Coverage Verification
- Table of Authorized Self-Insured Employers
- Table of Authorized Self-Insured Employers That Direct Medical Care
- Claims Division Annual Processing Statistics
- Commission Ombudsman
- Present Value Tables

ICA COMMUNITY

- ICA Community
- Join ICA Community
- Community Instructions and Resources

Visit our Web

https://ww zica.gov/div ns/claims-div n

Claims Division does…

- Issue legal Claim Notifications new claims to the carrier to accept or deny within 21 days
- Maintains the official Claims File, provides access upon request via Community or physical copies
- Reviews and issues awards related to Facial Scarring, Change of Doctors, Leave the State, Guardian ad Litem, Average Monthly Wage, Loss of Earning Capacity Awards, Bad Faith and Unfair Claims Handling, Petition for Rearrangement, etc.
- Review and approve referrals to ALJ for request for hearings and 1061(J).
- Audits notices to ensure they are legally compliant, including 104, 106, 107, etc.
- Hosts Monthly Out of State Adjuster training and post-test and annual claims seminar
- Ombudsman assistance for complex questions or issues for all parties (cannot give legal advice but can provide applicable laws).
- Has specialized staff available via email and phone in Claims, LEC, Average Monthly Wage, Ombudsman, Insurance matching for notifications issues or change/combine/delete questions.

The role of the Claims Division…

We are here to help all interested parties to a claim.

- If you don't hear from us, the adjuster is following industry best practices!
  - The adjuster is accepting the claim with a legally compliant 104 instead of waiting to be notified. We generally do not notify if the claim has already been accepted.
  - The adjuster are issuing a 108 with complete & correct calculations and appropriate 104. Claims Division issues a 109
  - If the claim closes with permanent impairment, you've established the wage and provided all appropriate closing notices & medical reports.

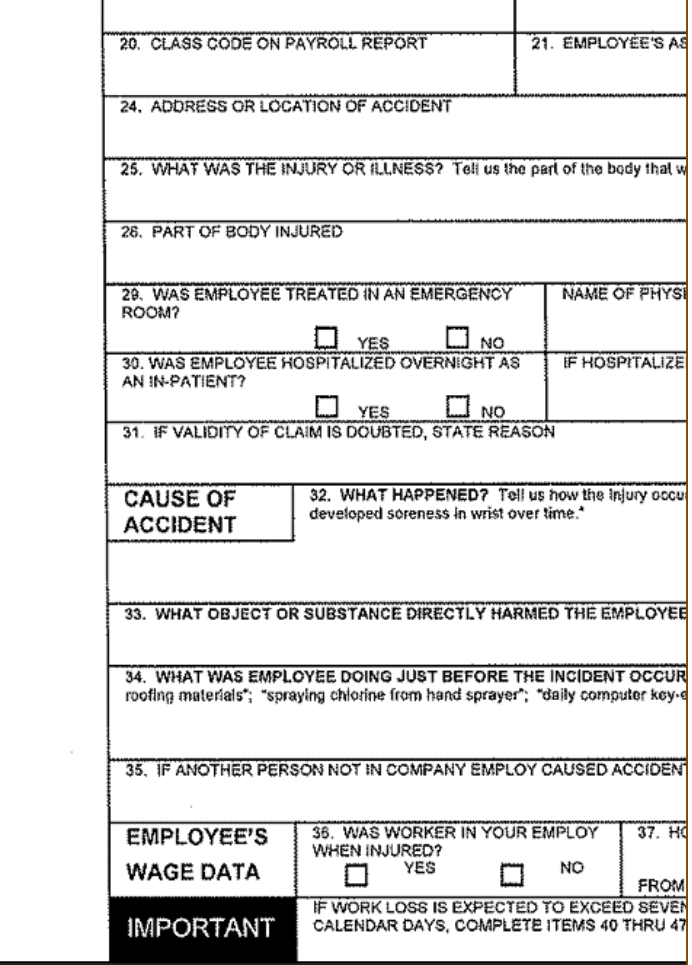
THANK YOU TO the SUPERSTARS FOLLOWING THESE BEST PRACTICES!

Claims Adjusting Overview

2020 SEMINAR MANUAL, CLAIMS ADJUSTING

The Beginning

HOW A CLAIM IS NOTIFIED



20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S AS

24. ADDRESS OR LOCATION OF ACCIDENT

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that w

26. PART OF BODY INJURED

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO | NAME OF PHYSI

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | IF HOSPITALIZE

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. WHAT HAPPENED? Tell us how the injury occu
developed soreness in wrist over time."

33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE

34. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCUR
roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-e

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDEN

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO | 37. HO FROM

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

EMPLOYER'S REPORT OF INDUSTRIAL INJURY

COMPLETE AND MAIL THIS REPORT WITHIN 10 DAYS FROM NOTICE OF ACCIDENT. FATALITIES MUST BE REPORTED WITHIN 24 HOURS.

Employer must, on this form, notify his insurance carrier of every injury or disease suffered by an employee, fatal or otherwise, which is claimed to arise out of or in the course of employment. ARIZONA REVISED STATUTES 23-908 & 23-1061

INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

MAIL TO: (CARRIER NAME & ADDRESS)

FOR CARRIER USE ONLY

FOR OSHA PURPOSES ONLY

OSHA Case #:

RECORDABLE INJURY

NON-RECORDABLE INJURY

EMPLOYEE 1. LAST NAME FIRST M.I. | 2. SOCIAL SECURITY NUMBER • | 3. BIRTH DATE

4. HOME ADDRESS (NUMBER & STREET) CITY STATE ZIP CODE | 5. TELEPHONE

6. SEX ☐ MALE ☐ FEMALE | 7. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

EMPLOYER 8. EMPLOYER'S NAME | 9. POLICY NUMBER | 10. NATURE OF BUSINESS (MANUFACTURING, ETC.)

11. OFFICE ADDRESS (NUMBER & STREET) CITY STATE ZIP CODE | 12. TELEPHONE

ACCIDENT 13. DATE OF INJURY OR ILLNESS | 14. TIME OF EVENT ☐ A.M. ☐ P.M. | 15. TIME EMPLOYEE BEGAN WORK ☐ A.M. ☐ P.M. | 16. DATE EMPLOYER NOTIFIED OF INJURY

17. LAST DAY OF WORK AFTER INJURY | 18. DATE OF RETURN TO WORK | 19. EMPLOYEE'S OCCUPATION (JOB TITLE) WHEN INJURED

20. CLASS CODE ON PAYROLL REPORT | 21. EMPLOYEE'S ASSIGNED DEPARTMENT | 22. DEPARTMENT NUMBER | 23. DID INJURY OCCUR ON EMPLOYER PREMISES? ☐ YES ☐ NO

24. ADDRESS OR LOCATION OF ACCIDENT CITY COUNTY STATE ZIP CODE

25. WHAT WAS THE INJURY OR ILLNESS? Tell us the part of the body that was affected and how it was affected; be more specific than "hurt," "pain," or sore." Examples: "strained back"; "chemical burn, hand"; "carpal tunnel syndrome."

26. PART OF BODY INJURED | 27. FATAL ☐ YES ☐ NO | 28. IF THE EMPLOYEE DIED, WHEN DID THE DEATH OCCUR? DATE OF DEATH

29. WAS EMPLOYEE TREATED IN AN EMERGENCY ROOM? ☐ YES ☐ NO | NAME OF PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL | ADDRESS (STREET, CITY, STATE & ZIP CODE)

30. WAS EMPLOYEE HOSPITALIZED OVERNIGHT AS AN IN-PATIENT? ☐ YES ☐ NO | IF HOSPITALIZED, HOSPITAL NAME | ADDRESS (STREET, CITY, STATE & ZIP CODE)

31. IF VALIDITY OF CLAIM IS DOUBTED, STATE REASON

CAUSE OF ACCIDENT

32. WHAT HAPPENED? Tell us how the injury occurred. Examples: "When ladder slipped on wet floor, worker fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; "Worker developed soreness in wrist over time."

33. WHAT OBJECT OR SUBSTANCE DIRECTLY HARMED THE EMPLOYEE? Examples: "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the incident, leave it blank.

34. WHAT WAS EMPLOYEE DOING JUST BEFORE THE INCIDENT OCCURRED? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. Examples: "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; "daily computer key-entry."

35. IF ANOTHER PERSON NOT IN COMPANY EMPLOY CAUSED ACCIDENT, GIVE NAME AND ADDRESS

EMPLOYEE'S WAGE DATA

36. WAS WORKER IN YOUR EMPLOY WHEN INJURED? ☐ YES ☐ NO | 37. HOURS PER DAY EMPLOYEE WORKED FROM A.M. P.M. THRU A.M. P.M. | 38. WAS EMPLOYEE ON OVERTIME WHEN INJURED? ☐ YES ☐ NO | 39. NUMBER OF DAYS PER WEEK USUALLY WORKED EMPLOYEE COMPANY

IMPORTANT

IF WORK LOSS IS EXPECTED TO EXCEED SEVEN CALENDAR DAYS, COMPLETE ITEMS 40 THRU 47

40. DATE OF LAST HIRE | 41. WAS WORKER PAID FOR DAY OF INJURY? ☐ YES ☐ NO IF YES, $ | 42. WAS EMPLOYEE HIRED FOR PERMANENT EMPLOYMENT? ☐ YES ☐ NO

43. NUMBER OF MONTHS EMPLOYED AVAILABLE DURING THE YEAR | 44. GIVE EMPLOYEE'S WAGE STATUS AS APPLICABLE HOUR DAY WEEK MONTH | 45. IS EMPLOYEE FURNISHED ☐ LODGING ☐ BOARD ☐ BOTH $ VALUE

47. DOES EMPLOYEE CLAIM DEPENDENTS? ☐ YES ☐ NO

IF EMPLOYEE IS PAID EXTRA PAY FOR OVERTIME, WHAT IS BASIS OF PAY? PER HOUR | 48. NUMBER OF HOURS OVERTIME CONSIDERED NORMAL PER WEEK

51. IF EMPLOYEE WORKED LESS THAN 12 MONTHS, SHOW GROSS WAGES FROM DATE OF HIRE THROUGH DAY PRIOR TO INJURY FROM THRU $

52. DATE OF LAST WAGE INCREASE IF WITHIN 12 MONTHS PRIOR TO INJURY | 53. WAGE BEFORE INCREASE $ | 54. WAGE AFTER INCREASE $ | 55. GROSS EARNINGS FROM DATE OF INCREASE THRU DAY PRIOR TO INJURY $

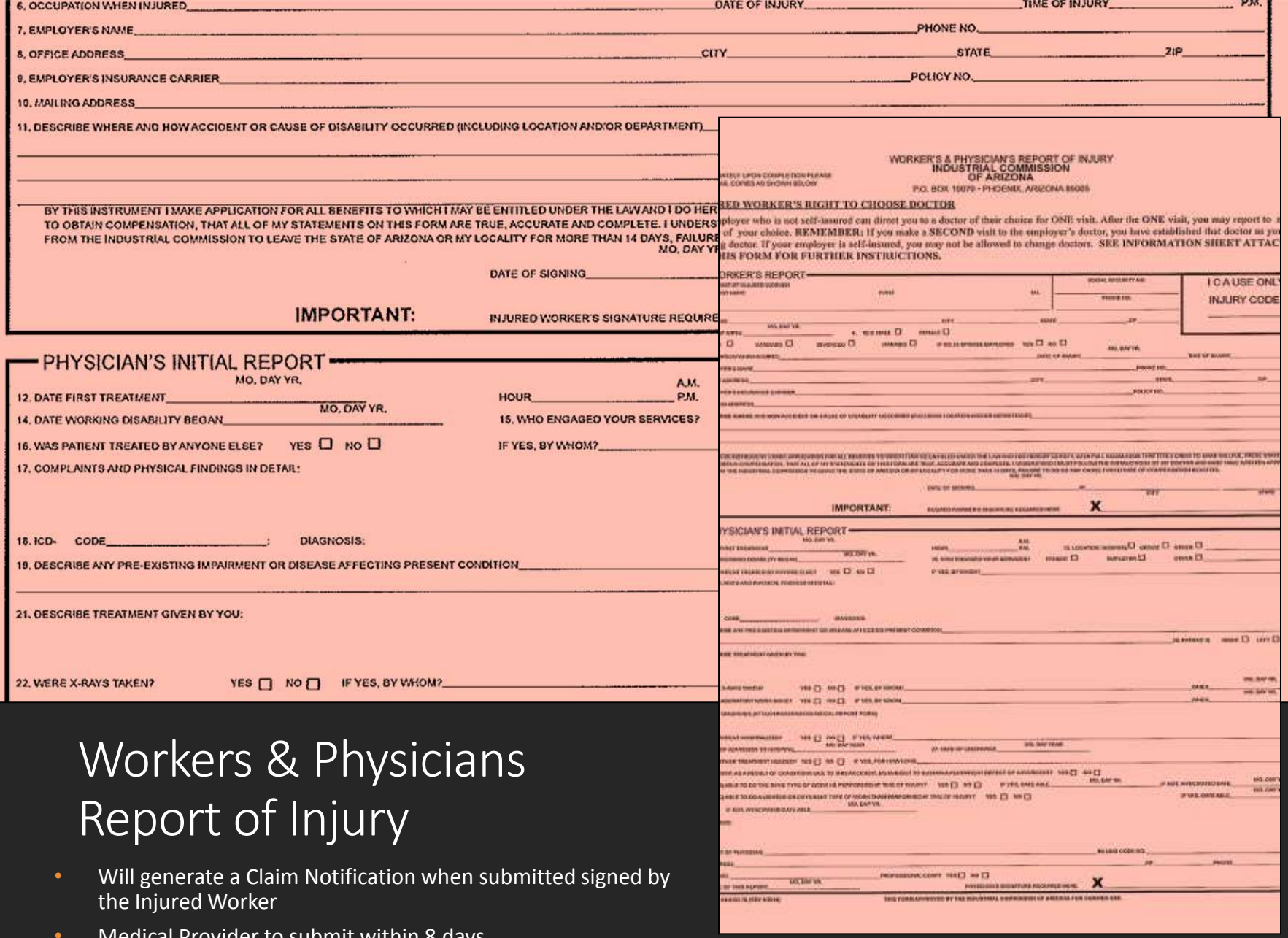
AUTHORIZED SIGNATURE DATE | AUTHORIZED SIGNATURE | TITLE

Employers Report of Injury - 101

Employer submits to ICA within 10 days, fatalities within 24 hours

Does not create legal notification

Available Online


6. OCCUPATION WHEN INJURED DATE OF INJURY TIME OF INJURY P.M.

7. EMPLOYER'S NAME PHONE NO.

8. OFFICE ADDRESS CITY STATE ZIP

9. EMPLOYER'S INSURANCE CARRIER POLICY NO.

10. MAILING ADDRESS

11. DESCRIBE WHERE AND HOW ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HER
TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERS
FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE
MO. DAY YE

DATE OF SIGNING

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRE

PHYSICIAN'S INITIAL REPORT

MO. DAY YR.

12. DATE FIRST TREATMENT HOUR A.M. P.M.

MO. DAY YR.

14. DATE WORKING DISABILITY BEGAN 15. WHO ENGAGED YOUR SERVICES?

16. WAS PATIENT TREATED BY ANYONE ELSE? YES ☐ NO ☐ IF YES, BY WHOM?

17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:

18. ICD- CODE ; DIAGNOSIS:

19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION

21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES ☐ NO ☐ IF YES, BY WHOM?

WORKER'S & PHYSICIAN'S REPORT OF INJURY
INDUSTRIAL COMMISSION
OF ARIZONA
P.O. BOX 19070 • PHOENIX, ARIZONA 85005

RED WORKER'S RIGHT TO CHOOSE DOCTOR

ployer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the ONE visit, you may report to
of your choice. REMEMBER: If you make a SECOND visit to the employer's doctor, you have established that doctor as yo
r doctor. If your employer is self-insured, you may not be allowed to change doctors. SEE INFORMATION SHEET ATTAC
HIS FORM FOR FURTHER INSTRUCTIONS.

ORKER'S REPORT

I CA USE ONL
INJURY CODE

IMPORTANT: X

YSICIAN'S INITIAL REPORT

X

Workers & Physicians Report of Injury

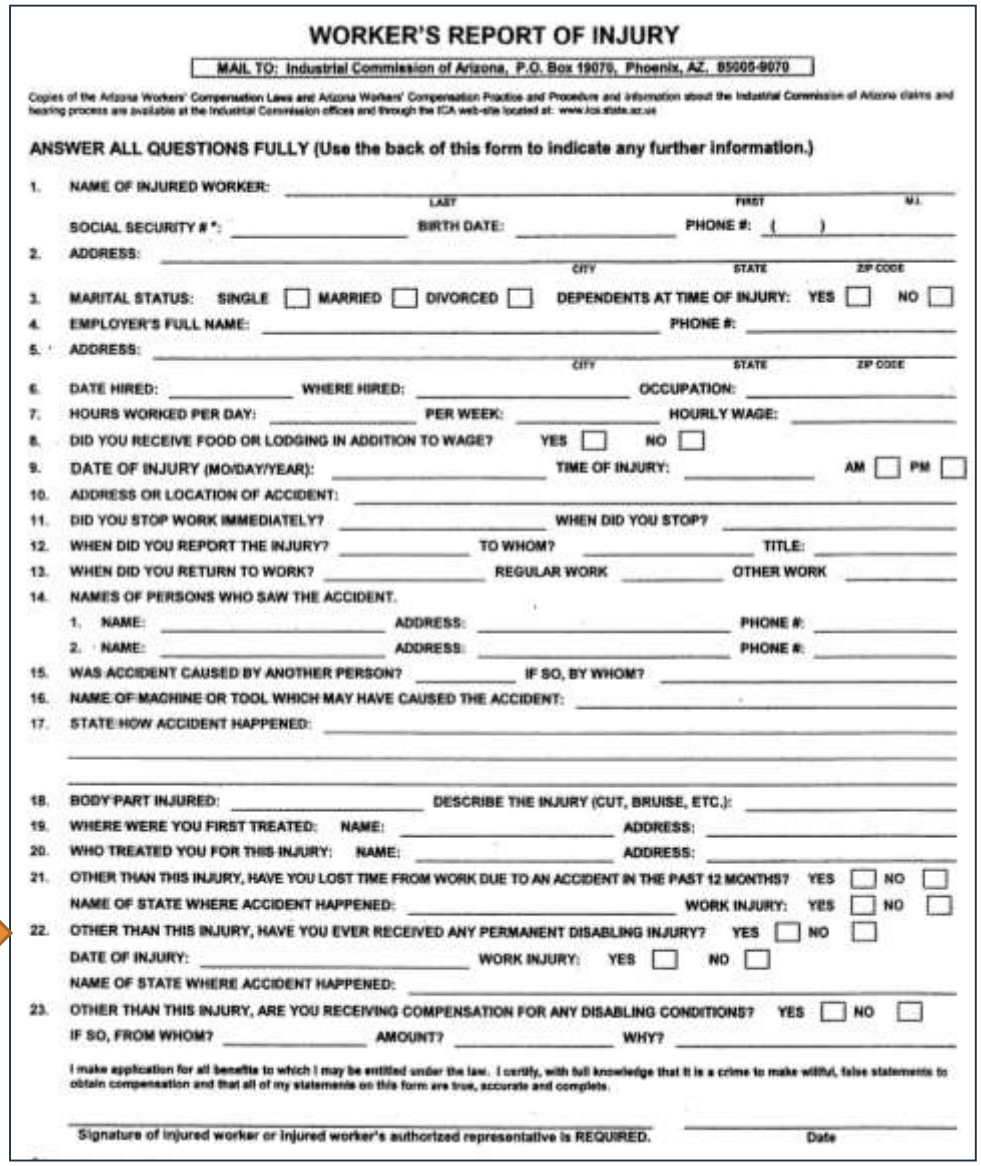
- Will generate a Claim Notification when submitted signed by the Injured Worker
- Medical Provider to submit within 8 days

Workers Report of Injury - 407

Will generate notification when submitted with signature of the Injured Worker

Available Online

*If the injured worker is being seen via telemedicine for the 1st visit, please direct to complete a 407



WORKER'S REPORT OF INJURY

MAIL TO: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, AZ, 85005-9070

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the Industrial Commission of Arizona claims and hearing process are available at the Industrial Commission offices and through the ICA web-site located at: www.ica.state.az.us

ANSWER ALL QUESTIONS FULLY (Use the back of this form to indicate any further information.)

1. NAME OF INJURED WORKER: _____ (LAST) _____ (FIRST) _____ (M.I.)
   SOCIAL SECURITY #*: _____ BIRTH DATE: _____ PHONE #: ( )
2. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
3. MARITAL STATUS: SINGLE ☐ MARRIED ☐ DIVORCED ☐ DEPENDENTS AT TIME OF INJURY: YES ☐ NO ☐
4. EMPLOYER'S FULL NAME: _____ PHONE #: _____
5. ADDRESS: _____ (CITY) _____ (STATE) _____ (ZIP CODE)
6. DATE HIRED: _____ WHERE HIRED: _____ OCCUPATION: _____
7. HOURS WORKED PER DAY: _____ PER WEEK: _____ HOURLY WAGE: _____
8. DID YOU RECEIVE FOOD OR LODGING IN ADDITION TO WAGE? YES ☐ NO ☐
9. DATE OF INJURY (MO/DAY/YEAR): _____ TIME OF INJURY: _____ AM ☐ PM ☐
10. ADDRESS OR LOCATION OF ACCIDENT: _____
11. DID YOU STOP WORK IMMEDIATELY? _____ WHEN DID YOU STOP? _____
12. WHEN DID YOU REPORT THE INJURY? _____ TO WHOM? _____ TITLE: _____
13. WHEN DID YOU RETURN TO WORK? _____ REGULAR WORK _____ OTHER WORK _____
14. NAMES OF PERSONS WHO SAW THE ACCIDENT.
    1. NAME: _____ ADDRESS: _____ PHONE #: _____
    2. NAME: _____ ADDRESS: _____ PHONE #: _____
15. WAS ACCIDENT CAUSED BY ANOTHER PERSON? _____ IF SO, BY WHOM? _____
16. NAME OF MACHINE OR TOOL WHICH MAY HAVE CAUSED THE ACCIDENT: _____
17. STATE HOW ACCIDENT HAPPENED: _____
18. BODY PART INJURED: _____ DESCRIBE THE INJURY (CUT, BRUISE, ETC.): _____
19. WHERE WERE YOU FIRST TREATED: NAME: _____ ADDRESS: _____
20. WHO TREATED YOU FOR THIS INJURY: NAME: _____ ADDRESS: _____
21. OTHER THAN THIS INJURY, HAVE YOU LOST TIME FROM WORK DUE TO AN ACCIDENT IN THE PAST 12 MONTHS? YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____ WORK INJURY: YES ☐ NO ☐
22. OTHER THAN THIS INJURY, HAVE YOU EVER RECEIVED ANY PERMANENT DISABLING INJURY? YES ☐ NO ☐
    DATE OF INJURY: _____ WORK INJURY: YES ☐ NO ☐
    NAME OF STATE WHERE ACCIDENT HAPPENED: _____
23. OTHER THAN THIS INJURY, ARE YOU RECEIVING COMPENSATION FOR ANY DISABLING CONDITIONS? YES ☐ NO ☐
    IF SO, FROM WHOM? _____ AMOUNT? _____ WHY? _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation and that all of my statements on this form are true, accurate and complete.

_____ _____
Signature of injured worker or injured worker's authorized representative is REQUIRED. Date

Notification

21 CALENDAR DAYS TO ACCEPT OR DENY THE CLAIM

INSURANCE MATCHING COMPLETED

THE INDUSTRIAL COMMISSION OF ARIZONA

NOTIFICATION OF WORKERS COMPENSATION CLAIMS

08/01/2019

Carrier

21 Calendar Days

You are hereby notified of the following claim(s):

Employer Name/Address	Claimant Name/Address	Social Security Number	Date of Injury	Policy Number	ICA Claim Number
Employer	Claimant				

The first installment of compensation is to be paid or right to compensation denied not later than twenty-one (21) days after 08/01/2019, the date of this written notification, pursuant to A.R.S. 23-1061 and 23-1062. Request for deletions or corrections for claims on this list must be provided to the Commission by separate letter.

Available Online

Combine – Delete Notification

Something wrong? Correction needed?

Common Issues:

- Wrong spelling
- Wrong employer
- Wrong insured
- Wrong date of injury

If request is denied by the Commission, payer must issue notice accepting or denying the claim.

ATTENTION: DELETE/COMBINE fax: (602) 542-3373

ICA Notification Date:

ICA Claim Number:

Name of Injured worker: _____

Date of Injury: Social security number:

REQUESTING DELETION OF NOTIFICATION FOR THE FOLLOWING REASON(S):

___ No coverage for this Insured: _____

Policy # Expired/Cancelled on:

We believe the correct insurance carrier is:

___ Duplicate notification (see below)

Other:

DUPLICATE NOTIFICATION: Please combine the above file with the file below:

ICA Notification Date:

ICA Claim Number: _____

Claimant name:

Date of Injury:

REQUESTING THE FOLLOWING CHANGE(S) AND/OR CORRECTION(S)

Name of Injured worker: _____

Date of Injury: _____

Social security number:

Other: _____

FROM: (Carrier or tpa) _____

_____ **Phone:** _____

Signature

What happens if you deny after 21 days?

23-1061(M) PENALTIES

THE CARRIER SHALL PAY IMMEDIATELY COMPENSATION AS IF THE CLAIM WERE ACCEPTED, FROM THE DATE THE CARRIER IS NOTIFIED…

When is 1st compensation due on a Temporary Disability Claim?

WITHIN 21 DAYS FROM ICA NOTIFICATION DATE

How to Accept or Deny a Claim

Claim Processes

Adjuster issues notices to interested parties to provide notification of changes in the status and protest periods.

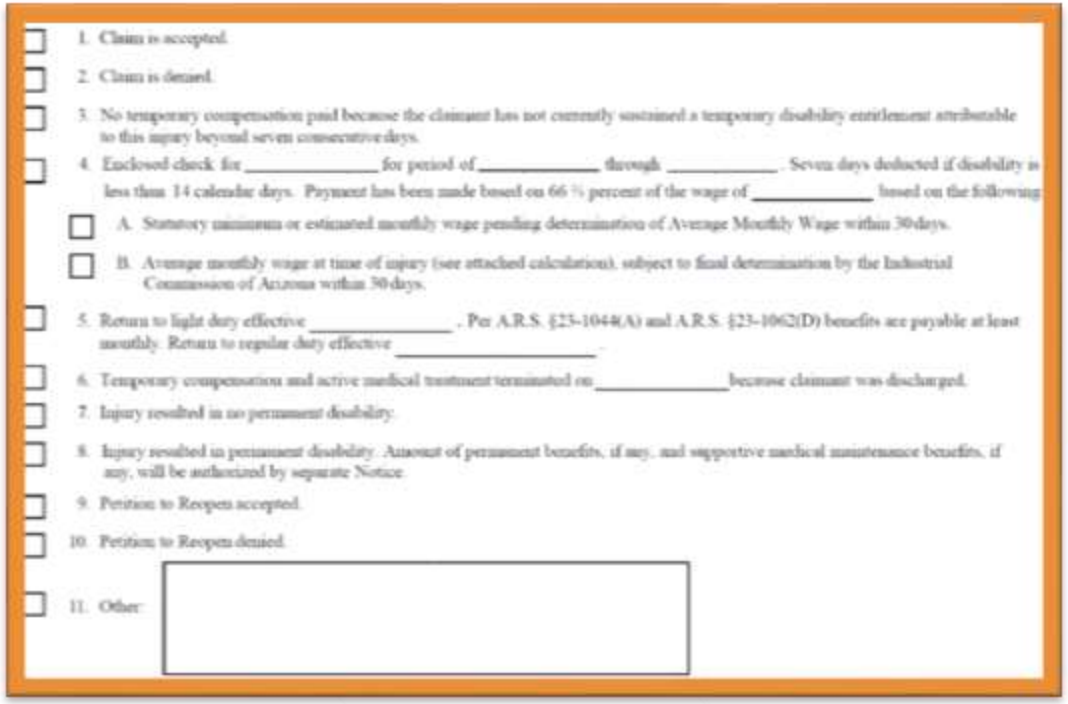
Copies go to all interested parties

- Injured Worker (or attorney)
- Employer
- Insurance Company
- Industrial Commission of Arizona
- Optional & Recommended: Medical Provider

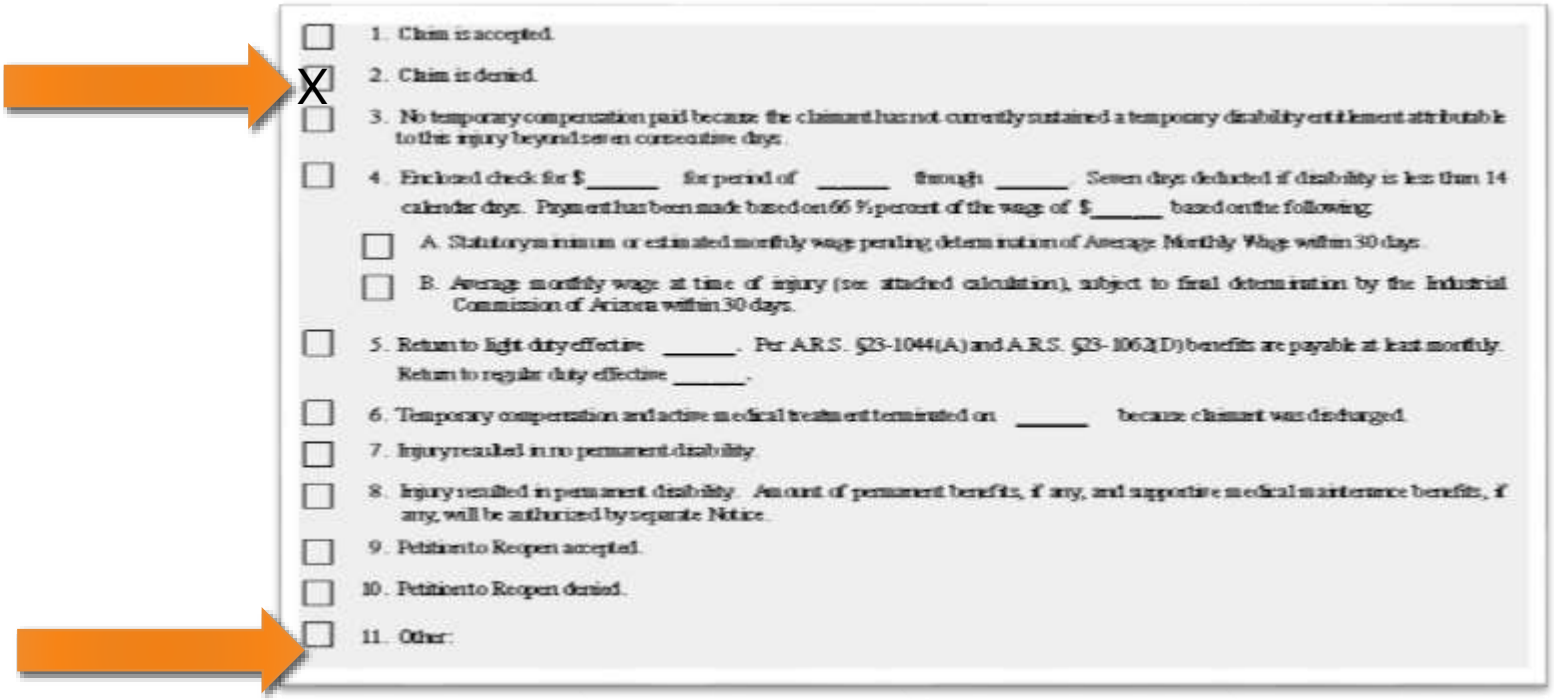
Notice of Claim Status - 104

Changes in claim status require the adjuster to issue appropriate notice to ALL interested parties.

104 is used for MOST status changes.



1. Claim is accepted.
2. Claim is denied.
3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
4. Enclosed check for _____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of _____ based on the following:
   - A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
   - B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
7. Injury resulted in no permanent disability.
8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
9. Petition to Reopen accepted.
10. Petition to Reopen denied.
11. Other:



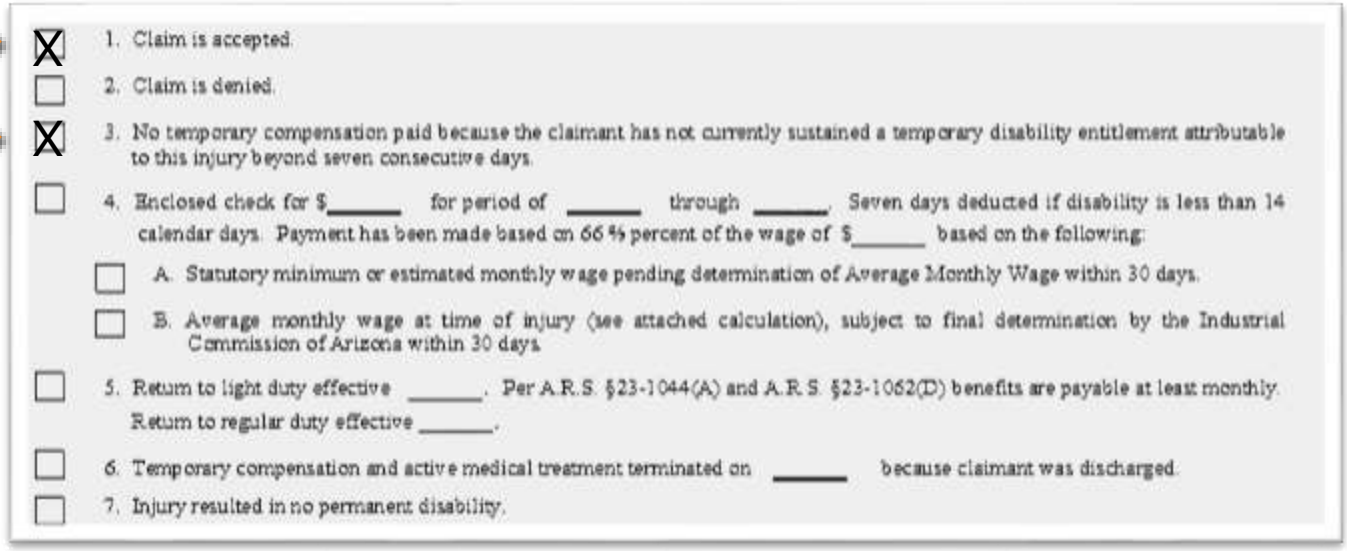
Denying a claim

RECOMMENDED LANGUAGE FOR #11 FOR APPLICABLE SCENARIOS

- NO COVERAGE ON DATE OF INJURY/WRONG CARRIER OF THE EMPLOYER
- NOT OUR INSURED
- DENIED AFTER 21 DAYS, COMMENT: PAYING PENALTY BENEFITS PER 23-1061(M)

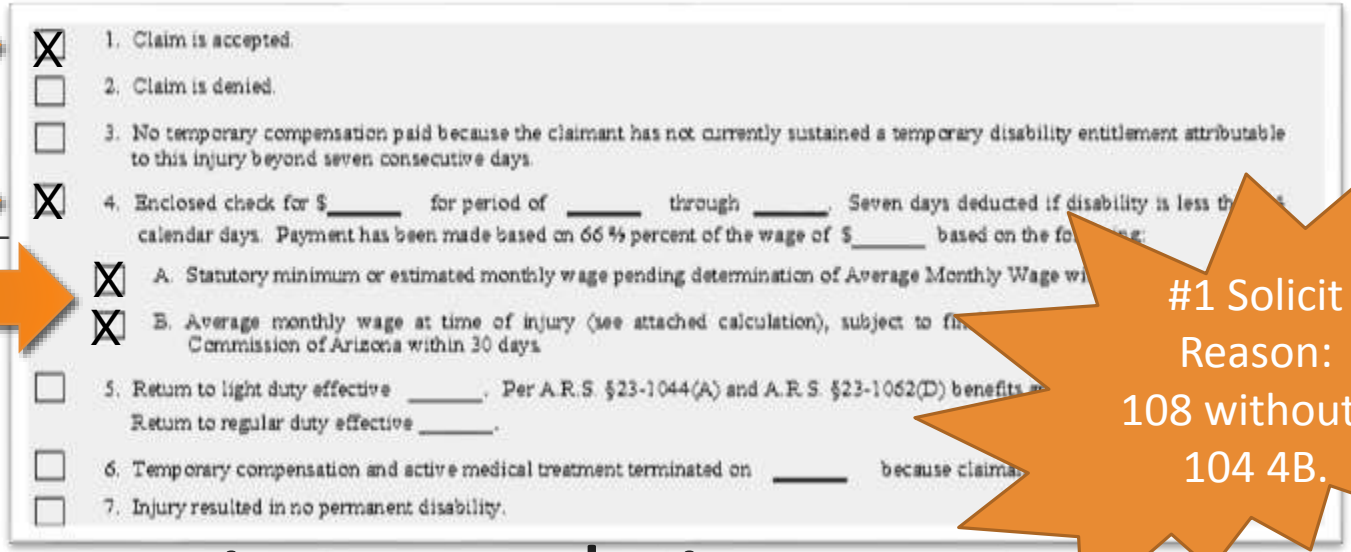
NOT OK: <u>NOT THE TPA</u>. WORK WITH YOUR CARRIER TO DIRECT THE MAIL TO CORRECT TPA SO A DECISION CAN BE MADE TIMELY.

MEDICAL ONLY



- [X] 1. Claim is accepted.
- [ ] 2. Claim is denied.
- [X] 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- [ ] 4. Enclosed check for $_____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $_____ based on the following:
  - [ ] A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
  - [ ] B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
- [ ] 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly.
  Return to regular duty effective _____.
- [ ] 6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
- [ ] 7. Injury resulted in no permanent disability.

Time Loss



- [X] 1. Claim is accepted.
- [ ] 2. Claim is denied.
- [ ] 3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
- [X] 4. Enclosed check for $_____ for period of _____ through _____. Seven days deducted if disability is less th
  calendar days. Payment has been made based on 66 ⅔ percent of the wage of $_____ based on the fo
  - [X] A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage wi
  - [X] B. Average monthly wage at time of injury (see attached calculation), subject to fi
    Commission of Arizona within 30 days.
- [ ] 5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits
  Return to regular duty effective _____.
- [ ] 6. Temporary compensation and active medical treatment terminated on _____ because claima
- [ ] 7. Injury resulted in no permanent disability.

OR

#1 Solicit Reason: 108 without a 104 4B.

Accepting a claim

Temporary Total Disability (TTD)
vs.
Temporary Partial Disability (TPD)

TTD – No Work

- 7 day waiting period, retroactive to the first day on the 14th day
- Payable every 14 days.
- Includes Dependent benefit of $25.00 (legal spouse or children).
- Accepting a claim with a 1 & 4 (a or b) is assumed to be off work. Changing to TPD requires a 104 #5.

TPD – Light Duty

- 7 day waiting period applies & retroactive effect applies.
- Able to take credit for earnings & unemployment
- Payable every 30 days
- Dependent benefit does not apply
- Accepting a claim with a 1 & 4 (a or b) is assumed to be off work. TPD requires a 104 #5.

RTLW
OR
RTRW

☐ 5. Return to light duty effective **RTW Date**. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly.

Return to regular duty effective **RTW Date**.

Change of work status

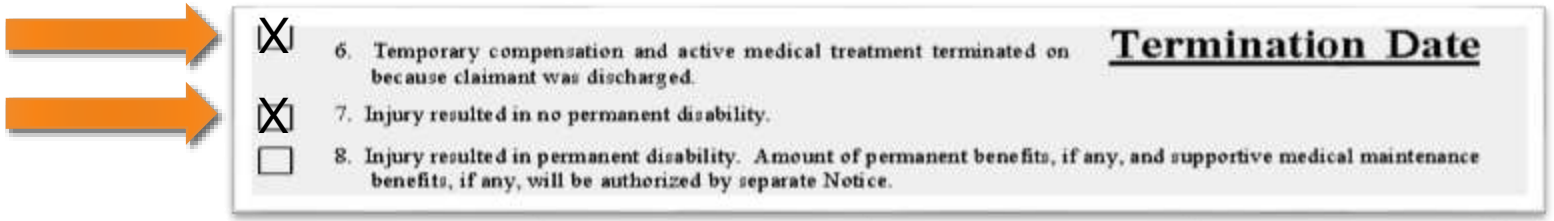
- MUST INCLUDE SUPPORTING MEDICAL RECORD

Claim Closure

DISCHARGE FROM ACTIVE CARE

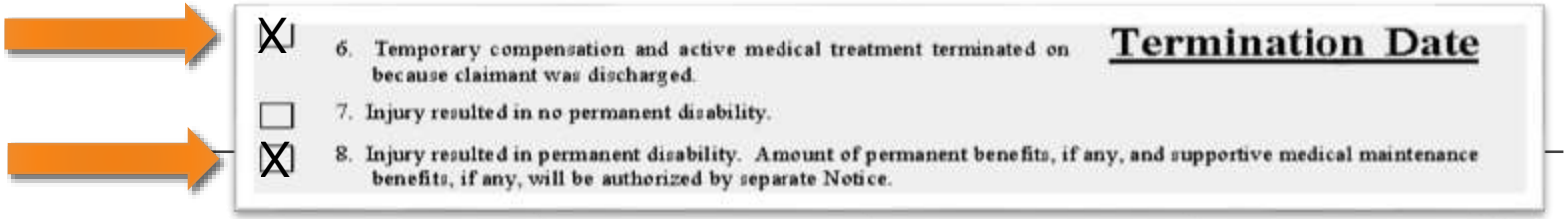
Medical Only

Does not require supporting medical documents



Time Loss

Without Permanent Impairment



With Permanent Impairment

Does require supporting medical documents

Terminating Active Benefits

advise the date of your next appointment.

If we do not hear from you within 20 days, we will proceed to close your claim. Please complete and sign as indicated below.

___ I am in need of further treatment. The date of my next appointment is: _____.

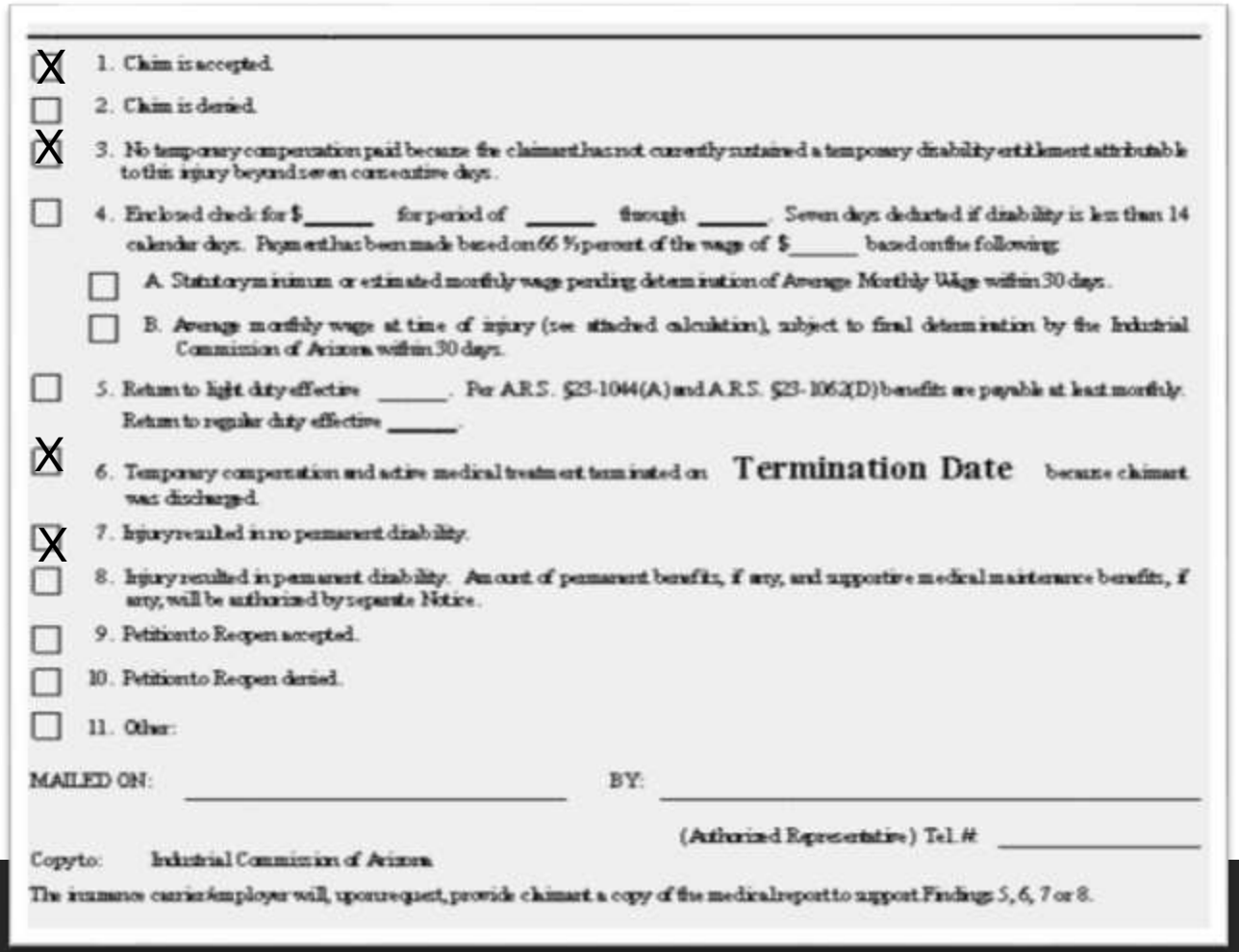
Administrative Closure Option

Sample in Forms

Be sure your version is FACTUAL.

Double Duty Notices

Accept & Close on the same notice!



1. Claim is accepted.
2. Claim is denied.
3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
4. Enclosed check for $_____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66 ⅔ percent of the wage of $_____ based on the following:
   - A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
   - B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
6. Temporary compensation and active medical treatment terminated on **Termination Date** because claimant was discharged.
7. Injury resulted in no permanent disability.
8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, if any, will be authorized by separate Notice.
9. Petition to Reopen accepted.
10. Petition to Reopen denied.
11. Other:

MAILED ON: _____ BY: _____

(Authorized Representative) Tel.#: _____

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

Other important rule for notices!

R5-20-118(A)

- A change in a claimant's status in an accepted claim cannot have a retroactive effect more than 30 days.

*This subsection does not apply if the acceptance is not final, a subsequent notice that affects death benefits, and the Commission can relieve a carrier or self-insured employer from a strict application of this subsection for good cause.

Supportive Medical Maintenance Benefits

- Form 103
- Note NEW FORM!
- Be specific!

NOTICE OF SUPPORTIVE MEDICAL MAINTENANCE BENEFITS

Carrier or Self-Insured Name and Address

Authorized Third Party Administrator (TPA) Name and Address

Claimant's Name and Address

ICA Claim No.

Soc. Sec. No.

Carrier Claim No.

Employer

Address

Date Injured

SUPPORTIVE MEDICAL MAINTENANCE BENEFITS ARE AUTHORIZED BY THE ABOVE-NAMED INSURANCE CARRIER AS SET FORTH BELOW WHILE THE NEED FOR SUCH SUPPORTIVE CARE CONTINUES OR UNTIL FURTHER NOTICE.

Supportive Medical Maintenance:

Treating Physicians(s):

Duration of Supportive Medical Maintenance:

IF CONDITION WORSENS REQUIRING ACTIVE MEDICAL CARE, A PETITION TO REOPEN MUST BE FILED WITH THE INDUSTRIAL COMMISSION. A.R.S. 23-1061(H).

MAILED ON:

BY:
(Authorized Representative) Tel. #

Copy to: Industrial Commission of Arizona

NOTICE TO CLAIMANT: If you do not agree with this NOTICE or wish to have the Commission investigate and review the benefits provided in this NOTICE, you must file a request for investigation under A.R.S 23-1061(J) with either office of the Industrial Commission listed below. A request for investigation seeking review of a Notice of Supportive Medical Maintenance Benefits may be filed at any time under A.R.S. 23-1061(J).

Change of Doctors

ONLY LIMITED SELF-INSURED MAY DIRECT CARE

PAYER CAN DIRECT CARE 1 TIME & REQUEST IME FROM TIME TO TIME

ADJUSTER CAN AUTHORIZE WITHOUT GOING THROUGH ICA

YES WE WANT YOUR OPINION

Change of Doctors

THE INDUSTRIAL COMMISSION OF ARIZONA
CLAIMS DIVISION

P.O. BOX 19070
PHOENIX, ARIZONA 85005-9070

REQUEST TO CHANGE DOCTORS

INJURED WORKER (First, Last):
ICA CLAIM#:
DATE OF INJURY:
CARRIER CLAIM #:
SOCIAL SECURITY #

PLEASE MAKE SURE TO PROVIDE THE COMPLETE NAME, ADDRESS AND TELPHONE NUMBER OF BOTH DOCTORS IN THE SPACE PROVIDED BELOW. FAILURE TO PROVIDE THIS INFORMATION MAY CAUSE A DELAY IN PROCESSING. IN ADDITION, MAKE SURE THE DOCTOR YOU ARE REQUESTING TO CHANGE TO IS WILLING TO PROVIDE YOU WITH MEDICAL CARE UNDER YOUR INDUSTRIAL CLAIM. YOU MUST SIGN THIS REQUEST.

REASON FOR REQUESTING CHANGE OF DOCTORS:

FROM: DOCTOR'S COMPLETE NAME, ADDRESS AND TELEPHONE NUMBER:

Doctor's Name
Address
City State Zip Code
PHONE #:

TO: DOCTOR'S COMPLETE NAME, ADDRESS AND TELEPHONE NUMBER:

Doctor's Name
Address
City State Zip Code
PHONE #:

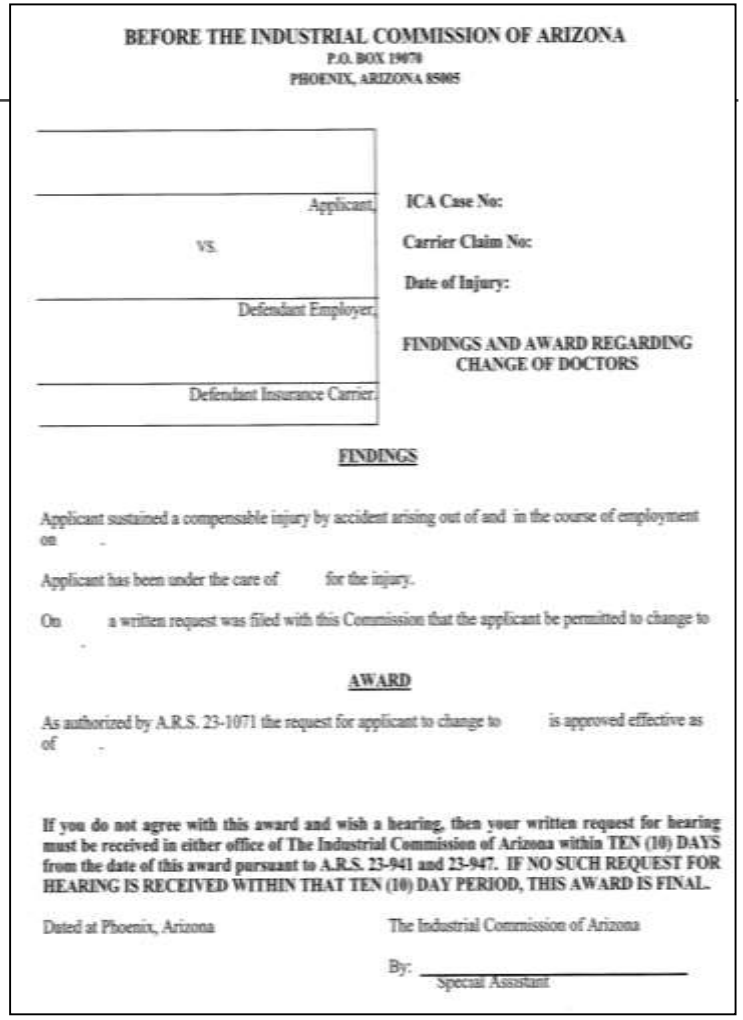
✓ INJURED WORKER'S SIGNATURE DATE:

Submitter Email Address

INJURED WORKER Address City State Zip Code INJURED WORKER Phone #

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

Claims ICA 0121-Rev 07.01.13



BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA
P.O. BOX 19070
PHOENIX, ARIZONA 85005

Applicant,

VS.

Defendant Employer,

Defendant Insurance Carrier.

ICA Case No:

Carrier Claim No:

Date of Injury:

FINDINGS AND AWARD REGARDING CHANGE OF DOCTORS

FINDINGS

Applicant sustained a compensable injury by accident arising out of and in the course of employment on .

Applicant has been under the care of for the injury.

On a written request was filed with this Commission that the applicant be permitted to change to .

AWARD

As authorized by A.R.S. 23-1071 the request for applicant to change to is approved effective as of .

If you do not agree with this award and wish a hearing, then your written request for hearing must be received in either office of The Industrial Commission of Arizona within TEN (10) DAYS from the date of this award pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH REQUEST FOR HEARING IS RECEIVED WITHIN THAT TEN (10) DAY PERIOD, THIS AWARD IS FINAL.

Dated at Phoenix, Arizona

The Industrial Commission of Arizona

By: _____
Special Assistant

Request to Leave the State

UNDER ACTIVE BENEFITS, THE INJURED WORKER MUST REQUEST APPROVAL TO LEAVE THE STATE IF ABSENT MORE THAN 14 DAYS.

NOT REQUIRED IF CLAIM IS CLOSED

REQUEST TO LEAVE THE STATE

INJURED WORKER (First, Last):
ICA CLAIM#:
DATE OF INJURY:
CARRIER CLAIM #:
SOCIAL SECURITY #

PLEASE, BEFORE MAILING MAKE SURE THAT THE FORM IS FILLED OUT COMPLETELY INCLUDING YOUR SIGNATURE THIS WILL HELP US PROCESS YOUR REQUEST MORE EFFICIENTLY.

REASON FOR REQUESTING TO LEAVE THE STATE:

LEAVING ON:

RETURNING ON:

OUT OF STATE ADDRESS

Address

City State Zip Code

PHONE #:

ATTENDING PHYSICIAN

Physician Name

Address

City State Zip Code

PHONE #:

✔ **INJURED WORKER'S SIGNATURE**

DATE

Submitter Email Address

INJURED WORKER Address City State Zip Code INJURED WORKER Phone #

* The mandatory requirement that the social security number be included in items filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

P.O. BOX 19070
PHOENIX, ARIZONA 85005

Applicant,

VS.

Defendant Employer,

Defendant Insurance Carrier.

ICA Case No:

Carrier Claim No:

Date of Injury:

FINDINGS AND AWARD REGARDING LEAVE THE STATE

FINDINGS

Applicant sustained a compensable injury by accident arising out of and in the course of employment on DATE.

On DATE a written request was filed with the Commission for the applicant to leave the State of Arizona indefinitely to reside in CITY AND STATE.

AWARD

As authorized by A.R.S. 23-1071 the request for applicant to leave the State of Arizona, while under the care of a qualified physician, is approved, effective as of DATE.

The carrier shall not be liable for the payment of medical expenses in relation to the injury of DATE during applicant's absence from the State of Arizona in excess of that provided by the Arizona Medical Fee Schedule or as approved by the carrier.

The applicant shall return to the State of Arizona once a year if directed by the carrier. The carrier shall pay, in advance, reasonable travel costs including transportation, food, lodging and loss of pay.

If you do not agree with this award and wish a hearing, then your written request for hearing must be received in either office of The Industrial Commission of Arizona within TEN (10) DAYS from the date of this award pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH REQUEST FOR HEARING IS RECEIVED WITHIN THAT TEN (10) DAY PERIOD, THIS AWARD IS FINAL.

Dated at Phoenix, Arizona

DATE

The Industrial Commission of Arizona

By: _____
Special Assistant

Suspension of Benefits

FORM 105

Suspending Benefits

NOTICE OF SUSPENSION OF BENEFITS

Carrier or Self-Insured Name and Address	ICA Claim No. _____
	Soc. Sec. No. _____
Authorized Third Party Administrator Name and Address	Carrier Claim No. _____
	Employer _____
Claimant's Name and Address	Address _____
	Date Injured _____

All compensation and medical payment benefits suspended by the above-named insurance carrier effective _____ because claimant:

- ☐ 1. Left the State of Arizona without the written approval of the Industrial Commission of Arizona.
- ☐ 2. Refused to submit to obstructed a medical examination.
- ☐ 3. Failed to submit a required annual report of income.

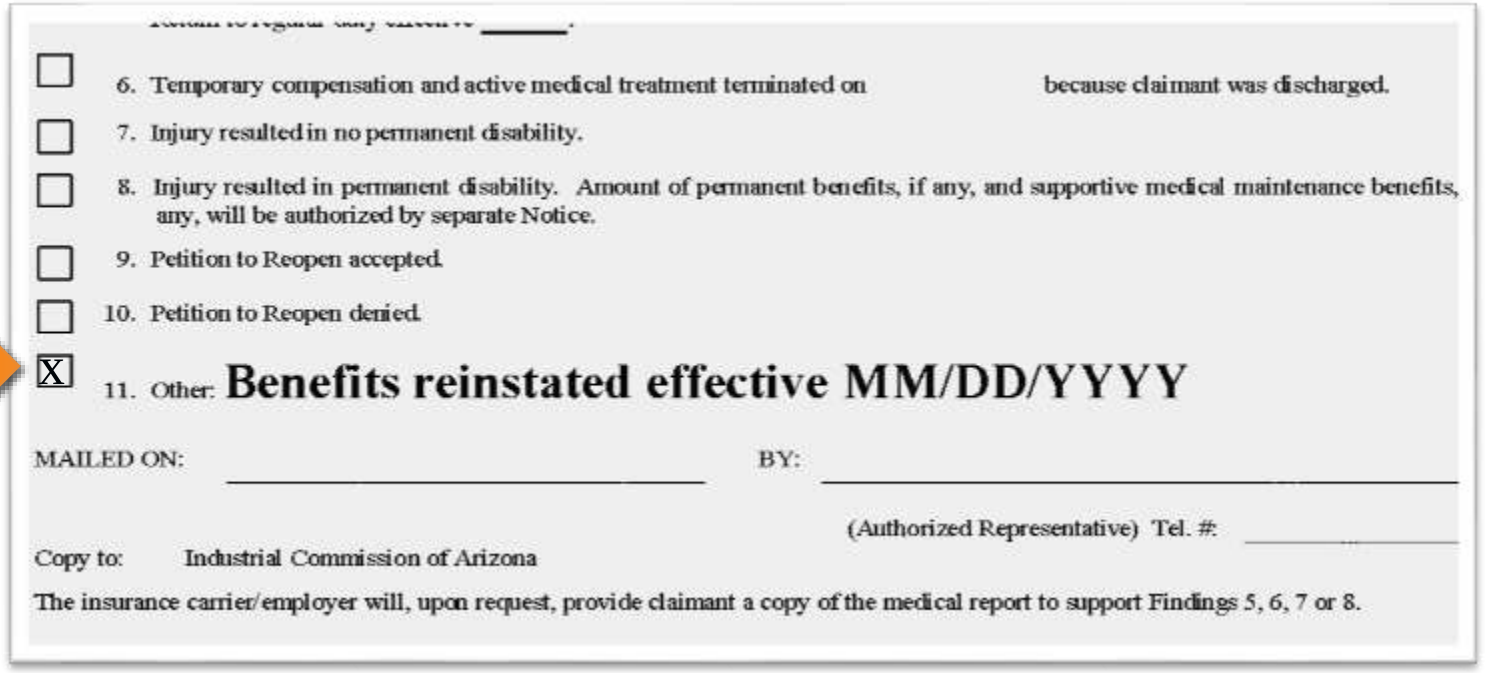
- ☐ All compensation benefits suspended by the above-named insurance carrier effective _____ because claimant is incarcerated. Medical benefits will continue. Any court-ordered child support payments are to continue.

*Incarcerated? Indemnity benefits only are suspended. Child Support Continues

Mailed On: _____ By: _____

Copy to: Industrial Commission of Arizona (Authorized Representative) Tel. #: _____

NOTICE TO CLAIMANT: If you do not agree with this NOTICE and wish a hearing on the matter, your written Request for Hearing must be received at either office of the Industrial Commission listed below within NINETY (90) DAYS after the date of mailing of this Notice, pursuant to A.R.S. 23-941 and 23-947. IF NO SUCH APPLICATION IS RECEIVED WITHIN THAT NINETY DAY PERIOD, THIS NOTICE IS FINAL.



6. Temporary compensation and active medical treatment terminated on _____ because claimant was discharged.
7. Injury resulted in no permanent disability.
8. Injury resulted in permanent disability. Amount of permanent benefits, if any, and supportive medical maintenance benefits, any, will be authorized by separate Notice.
9. Petition to Reopen accepted.
10. Petition to Reopen denied.
11. Other: **Benefits reinstated effective MM/DD/YYYY**

MAILED ON: _____ BY: _____

(Authorized Representative) Tel. #: _____

Copy to: Industrial Commission of Arizona

The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

When compliant with terms of suspension

Reinstate Benefits

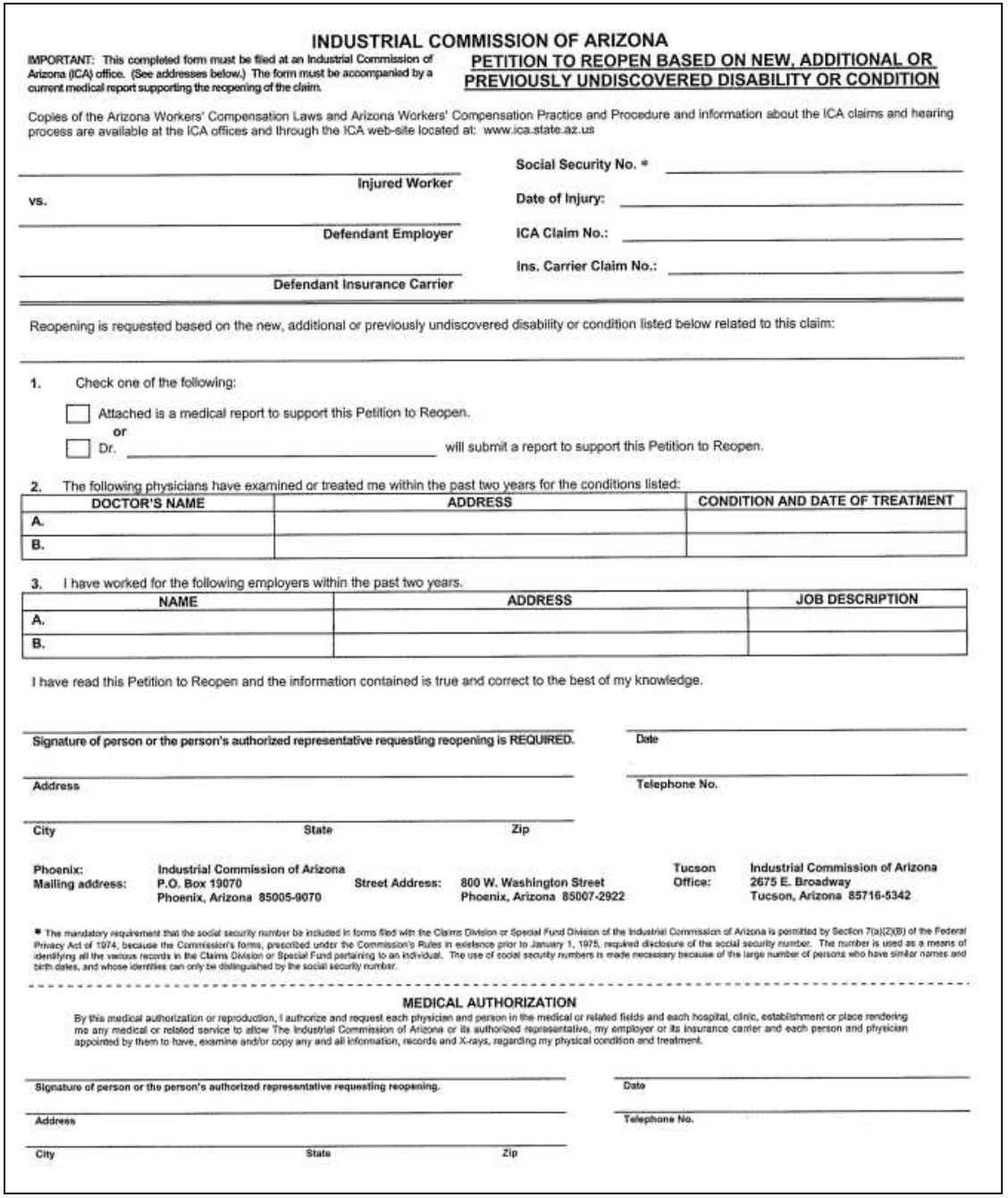
Petition to Reopen

LIFETIME RIGHT TO PETITION TO REOPEN A CLAIM FOR ACTIVE BENEFITS*

*UNLESS SETTLED FULL & FINAL

PTR Form

Injured worker (or representative) returns signed, dated with medical supporting the request.



INDUSTRIAL COMMISSION OF ARIZONA

IMPORTANT: This completed form must be filed at an Industrial Commission of Arizona (ICA) office. (See addresses below.) The form must be accompanied by a current medical report supporting the reopening of the claim.

PETITION TO REOPEN BASED ON NEW, ADDITIONAL OR PREVIOUSLY UNDISCOVERED DISABILITY OR CONDITION

Copies of the Arizona Workers' Compensation Laws and Arizona Workers' Compensation Practice and Procedure and information about the ICA claims and hearing process are available at the ICA offices and through the ICA web-site located at: www.ica.state.az.us

_____ Injured Worker

vs.

_____ Defendant Employer

_____ Defendant Insurance Carrier

Social Security No. * _____

Date of Injury: _____

ICA Claim No.: _____

Ins. Carrier Claim No.: _____

Reopening is requested based on the new, additional or previously undiscovered disability or condition listed below related to this claim:

_____

1. Check one of the following:

☐ Attached is a medical report to support this Petition to Reopen.

or

☐ Dr. _____ will submit a report to support this Petition to Reopen.

2. The following physicians have examined or treated me within the past two years for the conditions listed:

	DOCTOR'S NAME	ADDRESS	CONDITION AND DATE OF TREATMENT
A.			
B.			

3. I have worked for the following employers within the past two years.

	NAME	ADDRESS	JOB DESCRIPTION
A.			
B.			

I have read this Petition to Reopen and the information contained is true and correct to the best of my knowledge.

_____ Signature of person or the person's authorized representative requesting reopening is REQUIRED.

_____ Date

_____ Address

_____ Telephone No.

_____ City _____ State _____ Zip

Phoenix:
Mailing address: Industrial Commission of Arizona, P.O. Box 19070, Phoenix, Arizona 85005-9070

Street Address: 800 W. Washington Street, Phoenix, Arizona 85007-2922

Tucson Office: Industrial Commission of Arizona, 2675 E. Broadway, Tucson, Arizona 85716-5342

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7(a)(2)(B) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's Rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.

MEDICAL AUTHORIZATION

By this medical authorization or reproduction, I authorize and request each physician and person in the medical or related fields and each hospital, clinic, establishment or place rendering me any medical or related service to allow The Industrial Commission of Arizona or its authorized representative, my employer or its insurance carrier and each person and physician appointed by them to have, examine and/or copy any and all information, records and X-rays, regarding my physical condition and treatment.

_____ Signature of person or the person's authorized representative requesting reopening.

_____ Date

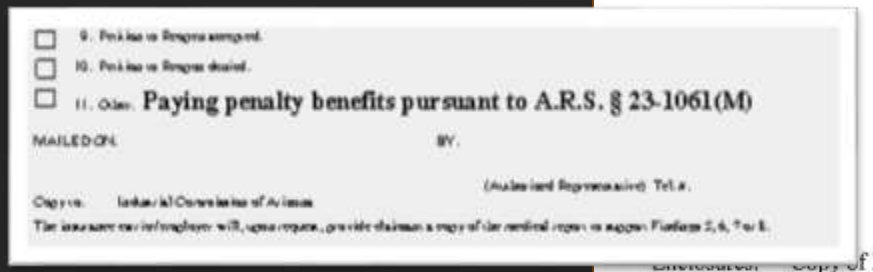
_____ Address

_____ Telephone No.

_____ City _____ State _____ Zip

Notification

- 21 Days to accept or deny
- 1061(M) Penalty benefits are payable if denied late
- Accept or Deny on 104


☐ 9. Petition to Reopen accepted.
☐ 10. Petition to Reopen denied.
☐ 11. Other. **Paying penalty benefits pursuant to A.R.S. § 23-1061(M)**
MAILED ON BY.
(Authorized Representative) Tel. #.
Copy to: Industrial Commission of Arizona
The insurance carrier/employer will, upon request, provide claimant a copy of the medical report to support Findings 2, 6, 7 or 8.

THE INDUSTRIAL COMMISSION OF ARIZONA

CLAIMS DIVISION
P.O. BOX 19070
PHOENIX, ARIZONA 85005

DALE L. SCHULTZ, CHAIRMAN
JOSEPH M. HENNELLY, JR., VICE CHAIR
SCOTT P. LeMARR, MEMBER
ROBIN S. ORCHARD, MEMBER
STEVEN J. KRENZEL, MEMBER

JAMES ASHLEY, DIRECTOR

Claims Division: (602) 542-4661
Claims Division Fax: (602) 542-3373

DATE

CARRIER NAME
CARRIER ADDRESS

NOTIFICATION OF PETITION TO REOPEN

Re: Injured Worker:
ICA Case No:
Date of Injury:
Employer:
Carrier Claim No:

Attached is a copy of the Petition to Reopen filed on

You are required to inform this Commission and the injured worker of your acceptance or denial of the petition within TWENTY-ONE DAYS from the date of this notification in accordance with A.R.S. 23-1061-I.

The Claims Division
Compliance Section

Enclosures: Copy of Petition to Reopen
Copy of medical report

Copy: CLAIMANT

ICA Solicitation

REQUEST TO CORRECT A NOTICE ISSUED

GOOD FAITH LEGAL OBLIGATION TO RESPOND TIMELY

DO: RESPOND OR UPLOAD A RESPONSE

DO: INCLUDE A ICA CLAIM #

DO NOT: IF YOU GET A 2ND SOLICIT….

THE INDUSTRIAL COMMISSION OF ARIZONA

CLAIMS DIVISION

P.O. BOX 19070
PHOENIX, ARIZONA 85005

DATE

Claims Division: (602) 542-4661
Claims Division Fax: (602) 542-3373

CARRIER NAME
CARRIER ADDRESS

Re: Injured Worker:
ICA Case No:
Date of Injury:
Employer:
Carrier Claim No.

REFER TO ITEM(S) CHECKED BELOW. YOUR RESPONSE IS REQUIRED WITHIN 14 DAYS. R... WITH YOUR REPLY. FAILURE TO RESPOND WITHIN 14 DAYS COULD RESULT IN TH... PURSUING AN ALLEGATION OF BAD FAITH.

- ☐ Issue amended NCS to include authorized signature.
- ☐ Issue Amended NCS to include date on which NCS was issued.
- ☐ Issue amended NCS checking #3(NTL) or #4 (TL). If time loss, be sure to provide wage calculation sheet (108).
- ☐ Issue amended NCS checking #5 and provide the return to work date.
- ☐ Issue amended NCS checking #6 and provide date of termination of benefits.
- ☐ Issue amended NCS checking #7 (no perm.) or #8 (perm.). If permanent, be sure to issue Notice of Permanent Disability (106 or 107).
- ☐ Issue Notice of Permanent Disability (106 or 107).
- ☐ Issue amended 106. Notice should read _____% impairment to the _____
  Payment should be made at _____% of the AMW for _____ months. Total amount of award is $_____
- ☐ Issue amended 107. Check box # _____.
- ☐ You are requesting apportionment pursuant to A.R.S. 23-1065(B). Please submit copies of 106 for the prior injury.
- ☐ Issue Notice of Supportive Medical Maintenance Benefits.
- ☐ Issue amended NCS termination/return to work date can not exceed 30 days prior to the date the NCS was mailed. (See R20-5-118A.)
- ☐ A.R.S. 23-1061M violation. Issue NCS either accepting or denying the claim. If time-lost claim, set out penalty benefits.
- ☐ Submit medical documentation to support Notice issued on
- ☐ Other:

_____
The Claims Division

Respond within 14 DAYS!

2nd Warning

Dear Insurance Company,

Attached is a copy of a solicitation letter for which the Commission has received no response. Please review your records and provide a response or if a notice or response was sent, please provide a copy. Please remember in order to amend a notice you must issue a new notice.

To file your response upload a copy of the solicitation letter and your response as one document and select the Doc Type 'Returned Solicit' or 'Returned Wage Solicit', whichever one applies, using the Industrial Commission of Arizona Community Portal at https://azicawc.force.com/claims/s/. If you have not yet registered you will be required to do so in order to upload your response.

Please be advised that if we do not receive a response to the solicitation letter within fourteen (14) calendar days from the date of this letter, the Industrial Commission will conduct a bad faith investigation on our own motion pursuant to A.R.S. §23-930(C) and R20-5-163(B)(3) which could result in a $1000.00 civil penalty per violation. If you have any questions please do not hesitate to contact me.

Respond within 14 DAYS!

Bad Faith Allegations

COMES NOW the Industrial Commission of Arizona, and on its own motion under A.R.S. Section §23-930 (A) alleges that Indemnity Ins Company of North America has committed bad faith and/or unfair claim processing practices in the handling of the above workers compensation claim and incorporated herein by reference. The specific actions which violate A.A.C. R20-5-163 are as follows:

Pursuant to A.A.C. Sec. R20-5-163, your response to these allegations is required in this office within thirty (30) days.

This constitutes the Industrial Commission's Notice of investigation and, if appropriate thereafter the Commission will order penalty benefits under the provisions of A.R.S. §23-930.

I have this date mailed a copy of this notice to the person or entity named in the complaint.

THE INDUSTRIAL COMMISSION OF ARIZONA

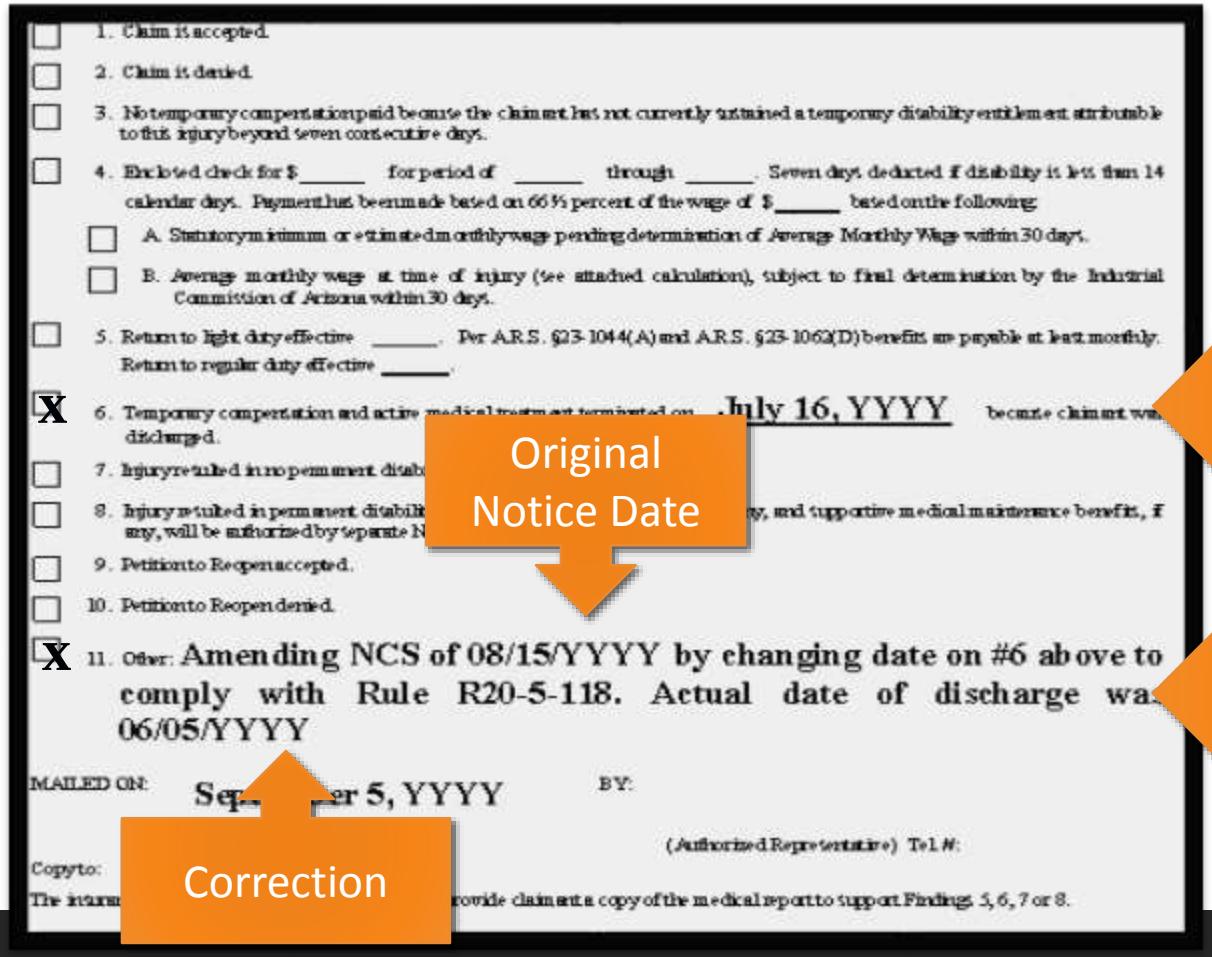
Respond within 30 DAYS!

Changing a notice

AMEND: TO CHANGE

RESCIND: TO REVOKE OR CANCEL

Amending a 104



1. Claim is accepted.
2. Claim is denied.
3. No temporary compensation paid because the claimant has not currently sustained a temporary disability entitlement attributable to this injury beyond seven consecutive days.
4. Enclosed check for $_____ for period of _____ through _____. Seven days deducted if disability is less than 14 calendar days. Payment has been made based on 66⅔ percent of the wage of $_____ based on the following:
   - A. Statutory minimum or estimated monthly wage pending determination of Average Monthly Wage within 30 days.
   - B. Average monthly wage at time of injury (see attached calculation), subject to final determination by the Industrial Commission of Arizona within 30 days.
5. Return to light duty effective _____. Per A.R.S. §23-1044(A) and A.R.S. §23-1062(D) benefits are payable at least monthly. Return to regular duty effective _____.
6. [X] Temporary compensation and active medical treatment terminated on July 16, YYYY because claimant was discharged.
7. Injury resulted in no permanent disab
8. Injury resulted in permanent disabilit ...y, and supportive medical maintenance benefits, if any, will be authorized by separate N
9. Petition to Reopen accepted.
10. Petition to Reopen denied.
11. [X] Other: Amending NCS of 08/15/YYYY by changing date on #6 above to comply with Rule R20-5-118. Actual date of discharge wa... 06/05/YYYY

MAILED ON: Sep...er 5, YYYY BY:

(Authorized Representative) Tel #:

Copy to:

The insurer ...rovide claimant a copy of the medical report to support Findings 5, 6, 7 or 8.

Original Notice Date

Corrected Info

Statement Correcting Info

Correction

Our most common reasons for Solicitations

Mail notice on ‘Mailed On’ date and/or full name of adjuster.

Attach supporting documentation when changing the claim status (include ICA Claim#)

- Closing for active benefits
- Release to light duty work from no work
- Release to regular work from light duty
  - *Supporting Documentation is not required on Medical Only/No Time Loss claims*

Our most common reasons for Solicitations, part 2

A 108 without a 104 with 4B checked

A Permanent Impairment Claim (usually with no time loss) Facial, Scheduled or Unscheduled claim without setting the average monthly wage

Not issuing an 104 Accepting the claim for benefits when notified

- We did not get the original, nor did we get a reply to solicitations because adjuster assumes we got the original (hint: we do not issue follow up solicits if we knowingly have a response)
- Different Dates of Injury
- Difficult investigations, employers not participating
- Delays in Carrier/TPA communications

Effective date cannot be greater than 30 days prior (Rule 5-20-118)

A toll-free number must be listed when processing is outside of Arizona

Notice issued by a TPA/Insurance group must list Self-Insured Employer or Insurance Company

We can Help!

Call: 602-542-4661

Email: Claims @azica.gov

Questions?

THANK YOU FOR JOINING US!